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OSTEOPATHIC MEDICAL BOARD
OF CALIFORNIA

BEFORE THE
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KAVEH SEAN FARHOOMAND, D.O.** 3231 Waring Court, Ste. G Oceanside, CA 92081 Osteopathic Physician's and Surgeon's Certificate No. 20A8295 Respondent.	Case No. 00-2011-003166 **ACCUSATION**

Complainant alleges:

PARTIES

1. Angelina M. Burton (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Osteopathic Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 13, 2002, the Board issued Osteopathic Physician's and Surgeon's Certificate Number 20A8295 to Kaveh Sean Farhoomand, D.O. (Respondent). The Osteopathic Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3600 of the Code states that the law governing licentiates of the Osteopathic Medical Board of California is found in the Osteopathic Act and in Chapter 5 of Division 2, relating to medicine.

5. Section 3600-2 of the Code states:

"The Osteopathic Medical Board of California shall enforce those portions of the Medical Practice Act identified as Article 12 (commencing with Section 2220), of Chapter 5 of Division 2 of the Business and Professions Code, as now existing or hereafter amended, as to persons who hold certificates subject to the jurisdiction of the Osteopathic Medical Board of California, however, persons who elect to practice using the term or suffix "M.D." as provided in Section 2275 of the Business and Professions Code, as now existing or hereafter amended, shall not be subject to this section, and the Medical Board of California shall enforce the provisions of the article as to persons who make the election. After making the election, each person so electing shall apply for renewal of his or her certificate to the Medical Board of California, and the Medical Board of California shall issue renewal certificates in the same manner as other renewal certificates are issued by it."

6. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"..."

7. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"...

"(f) Any action or conduct which would have warranted the denial of a certificate.

"..."

8. Section 2238 of the Code states that a violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

9. Section 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

"..."

10. Section 2241.5 of the Code states:

"(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

"(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

"(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

"(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

"...

"(3) Violates Section 2242 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs.

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"(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

"(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

"(e)..."

11. Section 725 of the Code provides:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

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12. Section 4021 of the Code states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

13. Section 4022 of the Code states, in pertinent part:

"'Dangerous Drug' or 'dangerous device' means any drug or device unsafe for self use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

". . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

14. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

COST RECOVERY

15. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

16. Respondent is subject to disciplinary action under sections 3600-2, 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients MH, EK and MT, as more particularly alleged hereinafter:

17. On or about May 27, 2011, this case was initiated by a complaint by the Board of Occupational Therapy (BOT) regarding Respondent's care and treatment of one of its licensees,

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patient MH,[1] who had a known substance abuse problem. In particular, Respondent's prescribing patterns were called into question by the BOT.

18. Patient MH:

A. Patient MH, born in 1959, was treated by respondent on approximately 10 visits during the period of December 2008 through February 2012. Her complaints included multiple musculoskeletal pain complaints (including shoulder, neck, back and knee) and foot pain, insomnia, nicotine dependence, alcohol dependence and anxiety.

B. Patient MH's patient chart for her visit dated December 2, 2008, reveals that respondent prescribed 160 x Norco 10/325[2] with four refills and 90 x Soma[3] 350 mg with four refills. Respondent issued these prescriptions to patient MH without documenting previous medications tried and failed (specifically regarding the need for prescribed opioid therapy), any failed non-steroidal attempts, previous non-pharmaceutical therapies, opioid risk assessment, addiction screen, substance abuse history, previous radiological studies, history of prior pain treatment, assessment of underlying or coexisting diseases or conditions, and/or documenting a recognized medical indication for the use of a controlled substance. No mention is made of the need for a follow-up appointment to re-evaluate the opioid regimen.

C. The note for patient MH's next visit to respondent, on or about January 29, 2009, reveals a complaint of insomnia for which she was prescribed Ambien CR[4] 12.5 mg and also

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[1] Patient MH was issued her Occupational Therapy Assistant (OTA) certificate by the BOT on or about February 17, 2006.

[2] Norco, a brand name for a hydrocodone combination product, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. Norco 10/325 contains 10 mg hydrocodone bitartrate and 325 mg acetaminophen (often abbreviated as "APAP").

[3] Soma, a brand name for carisoprodol, is a Schedule IV drug under the Uniform Controlled Substances Act and is prescribed by doctors in the U.S. as a muscle relaxant. Recreational users of carisoprodol usually seek its potentially heavy sedating, relaxant, and anxiolytic effects. Also, because of its potentiating effects on narcotics, it is often abused in conjunction with many opioid drugs.

[4] Ambien is a brand name for zolpidem, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative used for the short-term treatment of insomnia. Ambien CR is the extended release form of the tablet.

given a few samples of Lunesta[5] "to try." There are no notes regarding the duration or severity of the insomnia.

D. On or about February 3, 2009, patient MH's patient chart reveals a complaint of nicotine dependence and acute bronchitis. On neither of these two dates is any response of patient MH to pain or sedative medication, or any reason for continuing the current opioid regimen, recorded in her patient chart. There is no documentation regarding how the current opioid regimen has improved patient's functional status, activities of daily living or any adverse drug reactions, nor is there any documentation of a physical or psychological dependence opioid risk evaluation.

E. On or about August 19, 2009, at patient MH's request, respondent authorized an additional refill of 160 x Norco 10/325 tablets, by fax, with the caveat that she would have to see him in order to get a new prescription.

F. Patient MH next saw respondent on or about November 17, 2009, nine months after her previous visit. Her patient chart notes reveal that she was under a lot of stress, and both alcohol and nicotine dependent. The patient reported drinking three martinis per day and that her attempts to stop drinking caused the "shakes." Patient MH stated that she would like "to quit." No drug or alcohol history was obtained from the patient, and the patient chart contains no mention of whether the patient was referred to, or attending, an alcohol treatment program. No urine drug screen or subsequent addiction screen was performed and/or ordered, and no instructions were given for a follow-up appointment or for changing or discontinuing the Soma regime. No pain reassessment was performed. Patient MH was treated with a 35-day Librium[6] taper starting at 15 mg three times daily and decreasing weekly for six weeks.

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[5] Lunesta is a brand name for eszopiclone, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative and is used to treat insomnia.

[6] Librium is a brand name for chlordiazepoxide, a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Librium is a benzodiazepine.

G. No follow up appointments were made for patient MH to assess her progress with her alcohol withdrawal and/or to determine whether she had any problems maintaining abstinence.

H. On or about April 23, 2010, a Decision by BOT became effective, placing patient MH on three (3) years probation for reasons which included her conviction for reckless driving, and her possession of methamphetamine,[7] Oxycodone HCI Acetaminophen,[8] Vicodin,[9] marijuana and drug paraphernalia.

I. Patient MH's next visit to respondent was on or about June 24, 2010. Her patient chart for that date states that she was still drinking daily, but at a lower level of consumption. Respondent's treatment plan included Norco and Soma, to which he added 100 Xanax[10] .5 mg four times daily as needed for anxiety. No mention was made of any clinical diagnosis of anxiety using DSM IV criteria, no referral to psychiatry or psychology for further counseling, and there was no suicide risk assessment or follow-up plan other than a note by respondent that patient MH should return for a follow-up visit in one to two months.

J. Respondent failed to document any legitimate medical indication that would justify patient MH's continued use of Soma and the initiation of Xanax together with Norco 10/325, after being treated for alcohol withdrawal syndrome earlier.

K. In its letter dated July 7, 2010, BOT reminded respondent of patient MH's probation with BOT and her history of using dangerous drugs and controlled substances. Respondent was specifically informed of the conditions of patient MH's probation, which included requirements

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[7] Methamphetamine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d).

[8] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is combined with acetaminophen in medication such as Percocet.

[9] Vicodin is a brand name for acetaminophen and hydrocodone bitartrate, a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. In its lowest strength, it contains 5mg hydrocodone and 500 mg acetaminophen, while Vicodin ES contains 7.5 mg hydrocodone and 750 mg acetaminophen.

[10] Xanax is a brand name for alprazolam (a benzodiazepine), a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

that she: (1) abstain from controlled substances and alcohol; (2) submit biological fluid samples; (3) if prescribed controlled substances by a health professional, patient MH was required to request the health professional to submit a medical treatment plan to the BOT with details of the medication, its dosage and prescribed date, the patient's prognosis, the date on which the medication would no longer be required, and the effect of the medication on the patient's recovery plan; and (4) if required by the BOT, patient MH was also required to attend a chemical dependency support group for the duration of her probation.

L. On or about July 12, 2010, Respondent informed BOT as follows:

"[Patient MH] has chronic back pain and on stable dose of Norco and Soma for this and anxiety disorder for which she is on Xanax as needed. These are medications patient will need long-term and does not affect her recovery plan. Continue with your plans as is."

M. Patient MH next saw respondent on or about December 6, 2010. At this visit, no opioid risk assessment and pain functional assessment was documented, and neither a radiological evaluation nor physical therapy was ordered or performed. Respondent prescribed Norco, Soma and Xanax for patient MH.

N. A Controlled Substance Utilization Review and Evaluation System (CURES) report shows that, during the period June 24, 2010 through December 6, 2010, respondent prescribed patient MH approximately 1600 Norco 10/325 tablets and 500 .5 mg Xanax tablets.

O. On or about February 23, 2011, Respondent submitted the following medical treatment plan for patient MH to the BOT:

Medication	**Dosage**	**Prescribed Date**	**Prog-nosis**	**Date medication no longer required**	**Effect on recovery plan**
Norco (hydrocodone and acetaminophen)	10/325 mg	12/02/2008 11/17/2009 01/24/2010	Fair	Patient with chronic back pain so likely will need this permanently	Negligible to none
Soma (carisoprodol)	350 mg	12/02/2008 11/17/2009 01/24/2010	Fair	Patient with chronic back pain so likely will need this permanently, taking only at night	Negligible to none

Ambien CR	12.5 mg	01/29/2009	Good	Off currently	None
Librium	5 mg	11/17/2009	Good	Off currently	None
Xanax (Alprazolam)	0.5 mg	06/25/2010 02/08/2011	Fair	Unknown: patient uses this medication sporadically for anxiety episodes and not while working and it is difficult to foreknow when she may no longer have these events.	Unknown but likely minimal

P. Patient MH again saw respondent on or about March 24, 2011, at which time complaints of back pain, smoking, and anxiety were addressed. There is no recorded alcohol use history. Respondent prescribed 200 x Norco 10/325 with five refills and 120 x .5 mg Xanax with five refills for patient MH, with her known history of substance abuse and disciplinary history with the BOT.

Q. On or about April 12, 2011, the BOT sought to revoke patient MH's probation for reasons which included her having tested positive for both controlled substances and alcohol, as well as her failure to ensure that a medical treatment plan (for the controlled substances) was timely provided to the BOT.

R. On or about July 22, 2011, patient MH surrendered her OTA license.

S. Patient MH was seen again by respondent on or about July 25, 2011, at which visit her knee injury was discussed. Respondent continued to prescribe Norco 10/325, Soma and Xanax for patient MH.

T. Patient MH's next visit was on or about September 23, 2011. Respondent's examination of patient MH's knee revealed that it was tender but not unstable. During that visit, patient MH refused a steroid injection. Respondent continued to prescribe Norco 10/325, Xanax and Soma for patient MH.

U. Patient MH's final visit to respondent was on or about February 7, 2012. Her patient chart for that date states that patient MH was taking three Norco 10/325 per day "on average." Respondent discharged patient MH from his practice on that date, quoting the Board's

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investigation of his treatment of patient MH as the reason for the discharge, and referred her to a pain management physician.

V. Respondent's chart for patient MH is frequently illegible and contains no clear lists of problems, active and non-active medications, or an allergy profile.

W. During the course of respondent's treatment of patient MH, no pain management agreement was entered into, and no informed consent was obtained from patient MH regarding the risks and benefits of the prescribed controlled substances.

X. Respondent's chart for patient MH contains no medication lists that allow tracking of reasonable estimates of medication consumption of controlled substances.

Y. During the course of patient MH's treatment, she received ongoing prescriptions for both Xanax and Soma, each with significant dependence-producing properties and potential side-effects. At no time did respondent address these potential side-effects, in a known alcohol-dependent patient.

Z. At no time during patient MH's treatment did respondent obtain an adequate history of any prior narcotic therapy, including any names of any previous treating physicians. Her chart contains no records of previous diagnostic studies and no evidence of any radiographic investigation of the areas involved in patient MH's initial pain complaints (the neck, shoulder, and lower back), and no mention of any treatments beyond medical therapy.

AA. At no time during his treatment of patient MH did respondent pursue any further diagnostic, psychological or psychiatric evaluations, or treatment modalities.

BB. During the course of his treatment of patient MH, respondent did not perform a periodic review of patient MH's "chronic back pain," nor did he obtain a consultation to another appropriate specialist (orthopedic surgery, physical therapy, rehabilitation, psychiatry, addiction medicine, etc.) regarding her diagnosis and medical care.

CC. Despite several risk factors that would make chronic use of narcotics less beneficial or even risky, including a current smoking history, a personal history of addiction (alcohol, cocaine, methamphetamine), and ongoing psychiatric complaints (insomnia and anxiety), patient MH's chart contains no note documenting her risk of medication overuse or misuse.

DD. At no time during his treatment of patient MH did respondent obtain her informed consent for the use of narcotics and/or other controlled substances.

EE. No urine drug screen tests were ordered by respondent for patient MH, and no CURES reports generated.

FF. Respondent was grossly negligent in his care and treatment of patient MH which included, but was not limited to, the following:

(i) Failing to appropriately initiate and subsequently monitor patient MH's chronic narcotic therapy;

(ii) Failing to appropriately initiate and subsequently monitor patient MH's alcohol withdrawal;

(iii) Failing to include medication lists in patient MH's medical record that allow tracking of reasonable estimates of medication consumption of controlled substances by patient MH;

(iv) Prescribing multiple sedative medications to a patient with known alcohol dependence and failing to document the existence or absence of potential interacting side-effects; and

(v) Failing to document the indication for the ongoing prescribing of Xanax and Soma in a patient taking more than 60 mg per day of Hydrocodone with a history of alcohol dependence.

19. Patient EK:

A. Patient EK, born in 1954, was diagnosed and treated by respondent from approximately November 7, 2007, through April 20, 2011, for spinal stenosis, major depressive disorder, anxiety, and attention deficit disorder. During this period, respondent routinely prescribed between 200 and 300 x Vicodin ES tablets every one to three weeks, 90 x Valium[11] 10 mg tablets every four weeks, 90 x clonazepam[12] 2 mg tablets every four weeks, and 30 x Adderall[13] 30 mg tablets every four weeks.

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[11] Valium, a brand name for diazepam, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

12 Clonazepam, often sold under the brand name Clonopin, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous (continued...)

B. Patient EK first saw respondent on or about November 7, 2007, and provided a medical history which included spinal stenosis with chronic back pain, restless leg syndrome, muscle spasms, major depression, anxiety, panic disorder, and a history of a left broken foot. Her then current medications included Prozac,[14] Vicodin, Zanaflex,[15] Xanax and Abilify.[16] After conducting an examination of patient EK, respondent's diagnosis included "synovitis knees, loss of lumbar lordosis." His prescriptions given at this visit included 200 x Vicodin ES, 1 – 2 every six hours, with two refills, and 90 x Xanax 1 mg with two refills.

C. Respondent did not obtain any of patient EK's previous treatment records or diagnostic study results.

D. Patient EK's next visit to respondent was on or about January 18, 2008. At this visit, respondent issued prescriptions for 90 x Xanax 1 mg with five refills, 90 x Valium 10 mg with two refills and 300 x Vicodin ES with two refills. Respondent's understanding was that patient EK would be taking approximately 10 x Vicodin ES tablets, including approximately 7500 mg acetaminophen, per day.

E. The patient chart for patient EK makes no mention of the reason or need to titrate up the dose from 200 to 300 x Vicodin ES tablets per month.

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drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

[13] Adderall is a psychostimulant medication that contains amphetamine, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[14] Prozac (fluoxetine) is a selective serotonin reuptake inhibitors (SSRI) antidepressant, used to treat major depressive disorder, bulimia nervosa, obsessive-compulsive disorder, panic disorder, and premenstrual dysphoric disorder (PMDD).

[15] Zanaflex is a short-acting muscle relaxer, primarily used to treat spasticity by temporarily relaxing muscle tone.

[16] Abilify (aripiprazole) is an antipsychotic medication, primarily used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression). It is also used together with other medications to treat major depressive disorder in adults.

F. At patient EK's next visit, on or about March 5, 2008, respondent issued a second prescription for 300 x Vicodin ES with refills, along with prescriptions for Xanax, Cymbalta 60 mg, Abilify 10 mg and Valium.

G. On or about April 2, 2008, respondent authorized a refill of patient EK's prescription for 300 x Vicodin ES, which had last been filled on March 18, 2008.

H. On or about April 11, 2008, patient EK was again seen by respondent and given a prescription for 200 x Vicodin ES with two refills.

I. Patient EK next saw respondent on or about June 16, 2008 and was issued a prescription for 200 x Vicodin ES with two refills, along with prescriptions for Xanax and an increased dosage of Abilify 20 mg.

J. Patient EK's next visit to respondent was approximately eight months later, on or about February 5, 2009. Respondent diagnosed her as having degenerative disk disease of the spine with spinal stenosis, along with major depressive disorder, "anxiety state" and bipolar disorder. He issued her a prescription for 200 x Vicodin ES with two refills and 90 x Valium 10 mg with two refills, among others.

K. Respondent did not document any clinical diagnosis of patient EK's anxiety, using DSM IV criteria, and made no referral to psychology or psychiatry for further counseling of her complex psychiatric condition. He conducted no suicide risk assessment for patient EK and formulated no follow-up plan for the treatment of her anxiety.

L. Respondent neither obtained nor considered any previous objective data or current radiological evaluation, MRI, and/or EMG[17] test, to support his opioid regimen for patient EK.

M. After further visits on or about May 1, 2009 and July 30, 2009, respectively, respondent again saw patient EK on or about October 27, 2009. At that visit, respondent gave patient EK 10 x Percocet[18] 325 mg tablets, along with prescriptions for Vicodin ES and Xanax.

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[17] An electromyogram (EMG) measures the electrical activity of muscles at rest and during contraction. A patient with leg pain or numbness may have these tests to find out how much his/her nerves are being affected. These tests check the functioning of a patient's spinal cord, nerve roots, and nerves and muscles that work the legs.

[18] Percocet is a combination of oxycodone and acetaminophen. Oxycodone is a Schedule (continued...)

Patient EK's chart contains no notes supporting the use of two short-acting opioid agents, namely Vicodin ES and Percocet, in high doses to improve chronic pain.

N. For the period approximately February 5, 2009, through the end of December 2009, patient EK filled prescriptions for approximately 3,480 tablets of Vicodin ES, of which 2,280 tablets had been prescribed to her by respondent. Over the approximately 330 day period, this amounts to an average of more than 10 tablets, or 7.5 grams (7,500 mg) of acetaminophen, per day.[19]

O. During the period July 1, 2010, through April 6, 2011 (280 days), respondent prescribed patient EK 4,540 x Vicodin ES tablets which amounts to an average of approximately 16 tablets, or 12 grams of acetaminophen, per day.

P. During the period January 7, 2011, through April 6, 2011, a period of 90 days, respondent prescribed patient EK 900 x Vicodin ES tablets, which amounts to an average of 10 tablets, or 7.5 grams of acetaminophen, per day.

Q. On or about January 26, 2010, respondent again saw patient EK and diagnosed her with adult attention deficit disorder, for which he prescribed 30 x dextroamphetamine[20] 15 mg continuous release tablets. The chart shows no consideration of a possible adverse drug reaction of the high dose opioid regimen with benzodiazepine (Diazepam), a screening exam evaluation for ADD and/or diagnosis assessment for attention deficit disorder.

R. Respondent did not request any CURES report, liver function or other laboratory tests, metabolic profile or urine toxicology in his care and treatment of patient EK. No attempt was made to objectively monitor the safety and efficacy of, or patient EK's compliance with, the treatment she was receiving from respondent.

II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[19] Prior to 2011, the recommended maximum dose of acetaminophen for the average healthy adult over a 24 hour period, was four grams (4,000 mg). In or around July 2011, the drug manufacturers reduced this to three grams (3,000 mg) over any 24 hour period.

[20] Dextroamphetamine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

S. Respondent did not enter into any pain management agreement with patient EK, and failed to obtain her informed consent for the medications he prescribed for her.

T. Respondent failed to document a specific treatment plan or objective for patient EK.

U. Respondent did not periodically review the course of pain treatment of patient EK, or obtain any available new information about the etiology of the pain or the patient's state of health, quality of life, increased or decreased pain and/or level of function.

V. Respondent did not seek to coordinate the treatment of patient EK's complex pain problem with any pain specialist, orthopedic surgeon, physical therapist and/or for other physical medicine or rehabilitation.

W. Respondent failed to conduct any opioid risk assessment for patient EK, record her physical and psychological function, obtain any previous radiological studies, or take a history of current and prior substance abuse and/or any prior pain treatment.

X. Respondent's chart for patient EK is frequently illegible. It contains no medication lists that allow for tracking of reasonable estimates of medication consumption for controlled substances.

Y. Respondent was grossly negligent in his care and treatment of patient EK, which included, but was not limited to, the following:

(i) Failing to develop and record a treatment plan or pursue any further diagnostic evaluations, rehabilitation, and/or pain treatment modalities for patient EK;

(ii) Failing to appropriately initiate and subsequently monitor chronic narcotic therapy, including, but not limited to, respondent's failure to obtain a proper medical history, information regarding patient EK's previous narcotic use, information from her previous treating physicians including previous X-rays or other diagnostic studies, and/or respondent's failure to adopt any of the standard monitoring techniques such as conducting pill counts or obtaining CURES reports;

(iii) Failing to include medication lists in patient EK's medical record that allow tracking of reasonable estimates of medication consumption of controlled substances by patient EK; and

(iv) Prescribing Vicodin ES at an average level of more than 4 grams of acetaminophen, per day, over a period of more than 2 years.

20. Patient MT:

A. Patient MT, born in 1967, was seen by respondent from approximately May 25, 2007, through August 16, 2011, for the management of chronic pain.

B. Respondent prescribed 90 x Norco 10/325 tablets, with one refill, to patient MT on or about February 13, 2009. There are no notes in respondent's chart for patient MT which document this prescription or any reason therefor, or medical examination which preceded it.

C. On or about June 5, 2009, patient MT saw respondent. At this visit, respondent prescribed 160 x Norco 10/325 tablets, to be taken 1 – 2 tablets every four hours as needed, for pain. The total quantity of tablets or number of refills is not mentioned in the patient chart. Patient MT filled this prescription six times, for a total of 960 tablets, between June 5, 2009 and September 24, 2009.

D. Respondent conducted no opioid risk assessment, physical and psychological function relating to pain, obtained no substance abuse history and/or review of history of prior pain treatment from previous providers, and obtained no previous radiological studies for patient MT.

E. Patient MT was not required to enter into any opioid management agreement.

F. Patient MT's patient chart between June 5, 2009, and September 24, 2009, contains no documentation supporting the need for refills of the June 5, 2009, prescription for Norco 10/325 without an appropriate prior evaluation and examination. No treatment plan for patient MT is documented in her chart.

G. On or about September 29, 2009, patient MT again saw respondent and was prescribed Norco 10/325, 1 – 2 tablets every 4 hours as needed, for pain. The total quantity of tablets or number of refills is not specified. Patient MT filled this prescription and an additional five refills, for a total of 840 tablets, between October 14, 2009 and January 11, 2010.

H. An MRI report dated October 6, 2009, concludes that the patient has osteoarthritis of both knees, worse on the left in the patellofemoral region.

I. Patient MT next saw respondent on or about February 9, 2010 and was diagnosed with "MDD (major depressive disorder), anxiety state, insomnia, hypothyroidism, and osteoarthritis both knees." Respondent prescribed Norco 10/325, 1 – 2 tablets every 4 hours as

needed, for pain, Temazepam[21] 30 mg at bedtime as needed, and increased the existing Xanax prescription to 1 mg every 6 hours as needed. Patient MT's chart for this date contains no reference to an orthopedic consultation nor to any psychiatric or psychological consultation or an evaluation for sleep depression. There is no documentation of any discussion of the risks associated with the concurrent use of opioids with benzodiazepines in patient MT's chart.

J. During the period between approximately January 11, 2010, and September 2, 2010, a period of 235 days, patient MT obtained a total of 2,220 x Norco 10/325 tablets, which were prescribed by respondent.

K. On or about September 2, 2010, patient MT saw respondent and informed him that she was taking 10 x Norco tablets per day and had pain in both knees as well as ankle, back, neck and shoulder pain. The assessment in patient MT's chart reads, "chronic back and lower extremity arthralgias secondary to diffuse degenerative joint and disk disease," and the plan is "follow up ... in six months or so, sooner if needed."

L. During the period between approximately September 3, 2010, and December 6, 2010, a period of 95 days, patient MT obtained a total of 2,000 x Norco 10/325 tablets, which were prescribed by respondent and which averages just over 21 tablets, or more than 6.5 grams acetaminophen, per day. In addition, patient MT was taking Fioricet, which contains 325 mg acetaminophen per tablet, during the same period.

M. Patient MT again saw respondent on or about December 7, 2010, and was prescribed 180 x MS Contin[22] 30 mg to be taken twice daily and 180 x Norco 10/325 with four refills, along with continued prescriptions for Xanax and Temazepam.

N. During the period between approximately December 11, 2010, and March 1, 2011, a period of 81 days, patient MT obtained a total of 820 x Norco 10/325 tablets, 300 x Oxycodone

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[21] Temazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. Temazepam is a benzodiazepine, often sold under the brand name Restoril.

[22] MS Contin, a brand name for morphine, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

hcl 30mg tablets, 30 x Temazepam 30 mg tablets, 120 x Alprazolam 1 mg tablets, and 180 x Codeine Sulfate[23] 30 mg tablets, all of which were prescribed to her by respondent.

O. According to the patient chart, on or about January 18, 2011, patient MT called respondent, saying she wanted to try Oxycodone, and refused an orthopedic referral.

P. On or about March 2, 2011, patient MT's chart states that "pain is controlled with Oxycodone as needed." The assessment includes "osteoarthritis both knees ... worsening – recheck MRI – Ortho referral as needed." Respondent prescribed 180 x Oxycodone 30 mg tablets, to be taken one every four hours, as needed for pain.

Q. On or about the same date, respondent diagnosed patient MT with attention deficit disorder (ADD) and prescribed a "trial of Ritalin,"[24] concurrent with the Oxycodone. No clinical diagnosis of ADD, using DSM IV criteria and other diagnostic tools (such as radiological imagining and laboratory tests to rule out other possible etiologies), was made, and no screening exam, evaluation for and or psychiatry consultation for ADD was performed or documented.

R. During the period between approximately March 2, 2011, and May 11, 2011, a period of 71 days, patient MT obtained 540 x Oxycodone 30 mg tablets, 120 x Xanax 1 mg tablets, Ritalin and Adderall, all of which were prescribed to her by respondent. During the same period, patient MT obtained (and filled) a prescription for 120 x Norco 10/325 tablets from another physician. It is unclear from patient MT's chart whether respondent was aware of this additional prescription.

S. On or about May 12, 2011, patient MT's prescription for Oxycodone was increased by respondent from 30 mg tablets to the 60 mg dosage, to be taken 1 – 2 every four hours as needed. In addition, she was to continue the Xanax and Adderall. Patient MT's medical chart

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[23] Codeine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[24] Ritalin, a brand name for methylphenidate, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

contains no notes to support the increase in Oxycodone dosage with concurrent amphetamine (Adderall) and alprazolam (Xanax).

T. During the period between approximately May 12, 2011, and June 28, 2011, a period of 48 days, patient MT obtained a total of 480 x Oxycodone hcl 30 mg tablets, and 120 x Adderall 20 mg tablets, all of which were prescribed to her by respondent. In addition, patient MT obtained 90 x Oxycodone hcl 30 mg tablets from another physician. It is unclear from patient MT's chart whether respondent was aware of this additional prescription.

U. On or about June 29, 2011, patient MT filled a prescription from respondent for 150 x Norco 10/ 325 mg tablets.

V. On or about July 22, 2011, patient MT was admitted to Sharp Memorial Hospital for "recurrent headache" and discharged three days later with a discharge diagnosis that included acute liver failure of unknown etiology. Prior to this admission, patient MT had not been monitored for acetaminophen toxicity.

W. Patient MT was seen again on July 27, 2011, August 2, 2011 and on August 16, 2011. The assessment and plan on August 16, 2011, states, "osteoarthritis right greater than left knees – I have agreed to prescribe patient Oxycodone 30 mg three times daily 90 tablets for each 30 days and patient to see me at least every 3 months for exam. If needs more pain control patient to see pain management for analgesia."

X. On or about October 13, 2011, respondent documented a "referral to pain management," however, respondent continued to treat patient MT for pain with an opioid regimen until at least May 2012.

Y. Respondent was grossly negligent in his care of patient MT which included, but was not limited to, the following:

(i) Failing to develop and record a treatment plan or to pursue any further diagnostic evaluations, rehabilitation, and/or pain treatment modalities for patient MT;

(ii) Failing to include medication lists in patient MT's medical record that allow tracking of reasonable estimates of medication consumption for controlled substances;

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(iii) Failing to appropriately initiate and subsequently monitor the chronic narcotic therapy he prescribed for patient MT;

(iv) Overprescribing acetaminophen-containing narcotic analgesics to patient MT;

(v) Prescribing Norco to patient MT with presumed acute onset of liver disease of unknown etiology; and

(vi) Prescribing narcotics to patient MT on or about February 13, 2009, without conducting an appropriate prior examination and without documenting a medical indication for the prescription.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

21. Respondent is further subject to disciplinary action under sections 3600-2, 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he was repeatedly negligent in his care and treatment of patients MH, EK, MT and S.A., as more particularly alleged hereinafter.

22. Paragraphs 17 through 20, above, are hereby incorporated by reference and realleged as if fully set forth herein.

23. Respondent has committed repeated negligent acts in his care and treatment of patient MH, which included, but were not limited to, the following:

(a) Failing to appropriately initiate and subsequently monitor patient MH's chronic narcotic therapy;

(b) Failing to appropriately initiate and subsequently monitor patient MH's alcohol withdrawal;

(c) Prescribing multiple sedative medications to a patient with known alcohol dependence and/or failing to document the existence or absence of potential interacting side-effects;

(d) Failing to document the indication for the ongoing prescribing of Xanax and Soma in a patient taking more than 60 mg per day of Hydrocodone with a history of alcohol dependence;

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(e) Failing to appropriately diagnose, develop and record an appropriate treatment plan for the chronic opioid pain management of patient MH;

(f) Failing to obtain and record an adequate history, including but not limited to opioid risk assessment, documentation of previous medications tried and failed, the need for prescribed opioid therapy, failed non-steroidal attempts, previous non-pharmaceutical therapies, addiction screen, substance abuse history, previous radiological studies, history of prior pain treatment, assessment of underlying or coexisting diseases or conditions and documentation of the presence of a recognized medical indication for the use of a controlled substance;

(g) Failing to pursue any further diagnostic, psychological and/or psychiatric evaluations and treatment modalities for patient MH;

(h) Failing to include medication lists in patient MH's medical record that allow tracking of reasonable estimates of medication consumption of controlled substances by her;

(i) Failing to obtain patient MH's informed consent;

(j) Failing to perform a period review of patient MH's "chronic back pain;" and

(k) Failing to maintain adequate and accurate records of his care and treatment of patient MH.

24. Respondent has committed repeated negligent acts in his care and treatment of patient EK, which included, but were not limited to, the following:

(a) Failing to develop and record a treatment plan or pursue any further diagnostic evaluations, rehabilitation, and/or pain treatment modalities;

(b) Failing to include medication lists in patient EK's medical chart that allow tracking of reasonable estimates of medication consumption of controlled substances by her;

(c) Failing to appropriately initiate and subsequently monitor patient EK's chronic narcotic therapy;

(d) Failing to obtain and record a proper medical history, including but not limited to information of patient EK's previous narcotic use, information from her previous treating physicians and previous X-rays or other diagnostic studies, opioid risk assessment, physical and psychological function, pain reassessment and opioid addiction screen;

(e) Failing to adopt any of the standard monitoring techniques such as conducting pill counts or obtaining CURES reports;

(f) Prescribing Vicodin ES at an average level of more than 4 grams (4,000 mg) of acetaminophen per day, over a period of more than 2 years;

(g) Failing to obtain patient EK's informed consent regarding the risks and benefits of controlled substances;

(h) Failing to perform a periodic review of patient EK;

(i) Failing to obtain a psychiatric consultation and/or other consultation regarding the management of patient EK's pain; and

(c) Failing to maintain adequate and accurate records of his care and treatment of patient EK.

25. Respondent has committed repeated negligent acts in his care and treatment of patient MT which included, but were not limited to, the following:

(a) Failing to maintain adequate and accurate records of his care and treatment of patient MT;

(b) Failing to obtain a comprehensive history, including previous treatments, psycho-social factors, radiographic studies, co-existing medical conditions, substance abuse history, prior pain treatment from previous providers;

(c) Failing to enter into any opioid management agreement and/or discuss the risks and benefits of long-term opioid use with patient MT and/or obtain her informed consent;

(d) Failing to develop and record a treatment plan for patient MT;

(e) Failing to pursue any further diagnostic evaluations, rehabilitation, and/or pain treatment modalities;

(f) Failing to document any medical indication for repeated refills of tablets for patient MT without examination;

(g) Failing to refer patient MT for a psychological or psychiatric examination;

(h) Prescribing opioids concurrently with benzodiazepines;

(i) Failing to document the diagnosis of ADD;

(j) Failing to document an increased dosage of oxycodone;

(k) Failing to conduct an opioid risk assessment;

(l) Overprescribing acetaminophen-containing narcotic analgesics for patient MT;

(m) Prescribing Norco to a patient with presumed acute onset of liver disease of unknown etiology;

(n) Failing to include medication lists in patient MT's medical chart that allow tracking of reasonable estimates of medication consumption of controlled substances by her; and

(o) Prescribing narcotics to patient MT on or about February 13, 2009, without conducting an appropriate prior examination and without documenting a medical indication for the prescription.

26. Patient SA:

A. Patient SA, born in 1956, was diagnosed and treated by respondent from approximately June 18, 2008, through February 29, 2012, for hepatitis C, chronic fatigue and nicotine dependence.

B. Provigil[25] is used to treat excessive sleepiness caused by a diagnosed sleep disorder, such as obstructive sleep apnea, shift work sleep disorder, or narcolepsy. The maximum approved dose of the medication is 400 mg per day.

C. Respondent prescribed Provigil to patient SA for the off label use of treating her chronic fatigue and tiredness, not caused by any diagnosed sleep disorder and/or being secondary to hepatitis C. Respondent prescribed between 800 mg – 1,000 mg Provigil per day, for patient SA.

D. At no time during the course of his treatment of patient SA, did respondent obtain her informed consent regarding the risks and benefits of the use of controlled substances and/or for the off label use of Provigil and/or for the use of Provigil at a higher than approved dose.

E. Respondent's charts for patient SA are largely illegible.

[25] Provigil, a brand name for modafinil, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

F. Respondent has committed repeated negligent acts in his care and treatment of patient SA which included, but were not limited to, the following:

(i) Failing to maintain adequate and accurate records of his care and treatment of patient SA;

(ii) Failing to enter into a Controlled Substances Management Agreement and/or obtain patient SA's informed consent regarding the risks and benefits of the use of controlled substances; and

(iii) Prescribing Provigil for an off-label use, at a higher than approved dose, without patient SA's informed consent.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

27. Respondent is further subject to discipline under section 725 of the Code, in that he engaged in repeated acts of clearly excessive prescribing or administrating of drugs or treatment as determined by the standard of the community of licenses in his care and treatment of patients MH, EK and MT, as more particularly alleged in paragraphs 17 through 20, above, and which are hereby incorporated by reference and realleged as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without a Good Faith Prior Examination)

28. Respondent is further subject to discipline under sections 3600-2, 2227 and 2234, as defined by section 2242, of the Code, in that he prescribed, dispensed, or furnished dangerous drugs as defined in section 4022 without an appropriate prior examination and a medical indication, in his care and treatment of patient MT, as more particularly alleged in paragraph 20B, above, and which are hereby incorporated by reference and realleged as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(Violation of State Statutes Regulating Dangerous Drugs or Controlled Substances)

29. Respondent has further subjected his Osteopathic Surgeon Certificate No. 20A6132 to disciplinary action under sections 3600-2, 2227 and 2234, as defined by section 2238, of the Code, in that he violated state statutes regulating dangerous drugs or controlled substances in his

care and treatment of patients MH, EK and MT, as more particularly alleged in paragraphs 17 through 20, and 28, above, which are hereby incorporated by reference and realleged as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

32. Respondent has further subjected his Osteopathic Surgeon Certificate No. 20A6132 to disciplinary action under sections 3600-2, 2227 and 2234, as defined by section 2266, of the Code, in that failed to maintain adequate and accurate records regarding his care and treatment of Patients MH, EK, MT and SA, as more particularly alleged in paragraphs 17 through 20, above, which are hereby incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Osteopathic Medical Board of California issue a decision:

1. Revoking or suspending Osteopathic Physician's and Surgeon's Certificate Number 20A8295, issued to Respondent Kaveh Sean Farhoomand, D.O.;

2. Ordering Respondent Kaveh Sean Farhoomand, D.O., to pay the Osteopathic Medical Board of California the reasonable costs of the investigation and enforcement of this case pursuant to Business and Professions Code section 125.3, and, if placed on probation, the costs of probation; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 02-12-2013

ANGELINA M. BURTON
Executive Director
Osteopathic Medical Board of California
Department of Consumer Affairs
State of California
Complainant